Semi-Annual Report to the

Joint Legislative Oversight Committee

on Mental Health, Developmental Disabilities and Substance Abuse Services

Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2010-11: Spring Report

Session Law 2006-142

Section 2.(a)(c)

April 1, 2011

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Executive Summary

Legislation in 2006 (Session Law 2006-142, HB 2077 Section 2.(a)(c)) requires the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to report to the Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) every six months on progress made in seven statewide performance domains. This semi-annual report builds on the measures in the previous reports.

Domain 1: Access to Services – The system measures the number of individuals actually receiving services against the number of individuals projected to have a mental illness, developmental disability or substance use disorder based upon national prevalence rates. Among all the age-disability groups, a greater percentage of children estimated to have a mental illness are receiving services. Just over half of children (55%) and adults (51%) estimated to have a mental illness are provided services by the public system. Only 21% of children and 40% of adults estimated to have developmental disabilities are provided services by the public system. The few services provided to persons projected to have substance abuse problems (hovering around 10% of those estimated to be in need for both adolescents and adults) continues to be an area of significant concern. Over the past two calendar years, the timeliness of initial services for routine care has fluctuated and seen a high of 82% and most recently a low of 71%. The Division expects the current economic environment to bring more people to the public system, increasing the number of new requests for care, while current budget restrictions will make it more difficult for the public system to provide timely care to all those who need help.

Domain 2: Individualized Planning and Supports – Consumers with mental health and substance abuse disorders (regardless of age group) overwhelmingly report having a choice in their provider. The large majority of consumers with developmental disabilities report having some input in how they spend their day, money and free time (very similar to consumers in all participating states). In addition, the majority of consumers with developmental disabilities report their Case Managers are responsive to their needs. For mental health and substance abuse consumers, the large majority of children and adolescents report family involvement in service planning and treatment, with adolescent substance abuse consumers reporting the lowest level of family involvement.

Domain 3: Promotion of Best Practices – For mental health and substance abuse consumers, the last several quarters have shown significant increases in the use of a wider array of best practice services for both child and adult consumers. A greater number of persons discharged from the state alcohol and drug treatment centers or state psychiatric hospitals are being seen within seven days of their discharge.

Domain 4: Consumer-Friendly Outcomes – North Carolina consumers with developmental disabilities report strong participation in community life such as shopping, entertainment, going out to eat, running errands, and exercise/sports (very similar to reports from consumers in all other states). Parents and guardians of child mental health consumers were more likely to report services were very helpful to three key quality of life indicators than were adolescent mental health consumers. However, adolescent substance abuse consumers were more likely than adolescent mental health consumers to report services were very helpful in improving their quality of life, increasing their hope about the future, and increasing control over their own life. Compared to adult mental health consumers, adult substance abuse consumers were slightly more likely to report that services were very helpful to them in improving their education, housing, and employment.

Domain 5: Quality Management Systems – The Division is using NC DHHS' Open Window as a way to meet the objectives of DHHS Excels through continuous quality improvement.

Domain 6: System Efficiency and Effectiveness – The timely and accurate submission of data to the Division has improved over the past eight quarters, increasing from 69% to 87%. The submission of reports to the Division has remained consistently high, fluctuating between 91% and 98% over the past eight quarters.

Domain 7: Prevention and Early Intervention – The Federal Synar Amendment, Section 1926 of the Public Health Service Act, requires all states to conduct specific activities to reduce youth access to tobacco products. Over the past 15 years, the Synar Program has reduced tobacco sales to North Carolina's youth from 50% to 10% of attempted purchases.

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Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2010-11: Spring Report

Introduction

The *Mental Health, Developmental Disabilities and Substance Abuse Services Statewide System Performance Report* is presented in response to Session Law 2006-142, Section 2.(a)(c) and builds on the measures reported in previous semi-annual reports (See Appendix A).

Domain 1: Access to Services

Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse service needs who request help. Timely access is essential for helping to engage people in treatment long enough to improve or restore personal control over their lives, and to prevent crises. Both the Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcome Measures and Centers for Medicaid and Medicare Services (CMS) Quality Framework include measures of consumers' access to services.[1]

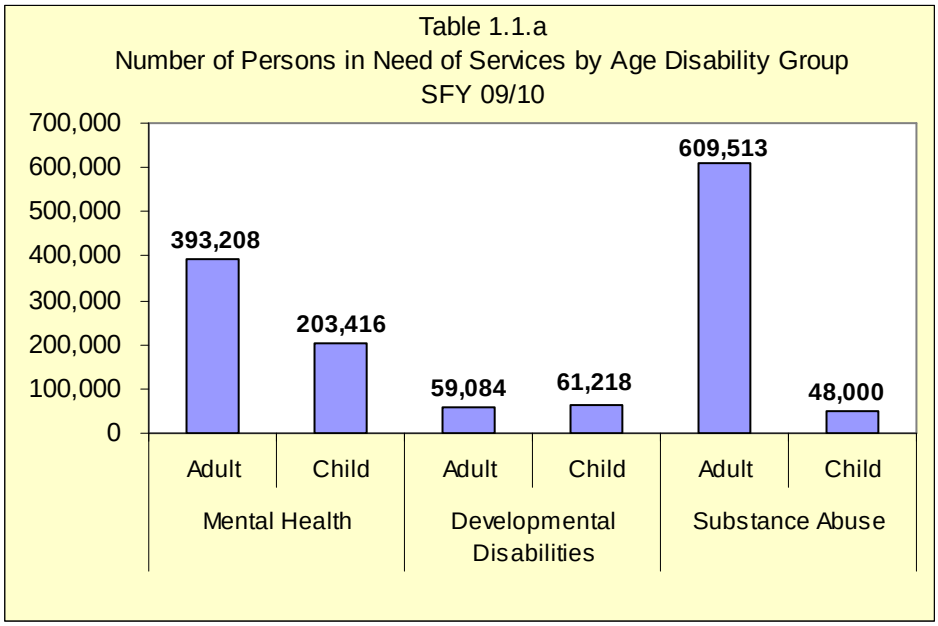
Measure 1.1: Persons Receiving Community Services

National research estimates the occurrence of chronic and serious mental health, developmental disabilities and substance abuse problems in the population (*prevalence*). (See Appendix D for sources.) Applying the most recent estimates to North Carolina's populations translates into 393,208 NC adults needing mental health (MH) services and almost 610,000 needing substance abuse (SA) services each year. Slightly more than 59,000 adults need services and supports for a developmental disability (DD).[2]

In terms of children and adolescents, just over 203,000 children experience MH problems each year that, if not addressed, can lead to a MH disorder (assuming the 12% prevalence rate for older youth, ages 9-17, also applies to children under age 9). Almost 61,000 children and adolescents (ages 0-17) in North Carolina have a developmental disability and another 48,000 adolescents (ages 12-17) experience a diagnosable SA disorder.

[1] See Appendix B for SAMHSA National Outcome Measures and Appendix C for CMS Quality Framework.

[2] The numbers presented here include all persons in North Carolina estimated to need mh/dd/sa services, including those who may be served by private agencies or other public systems.



SOURCE: Office of State Budget and Management (OSBM) State Demographics Unit, July 2010 population projection data.

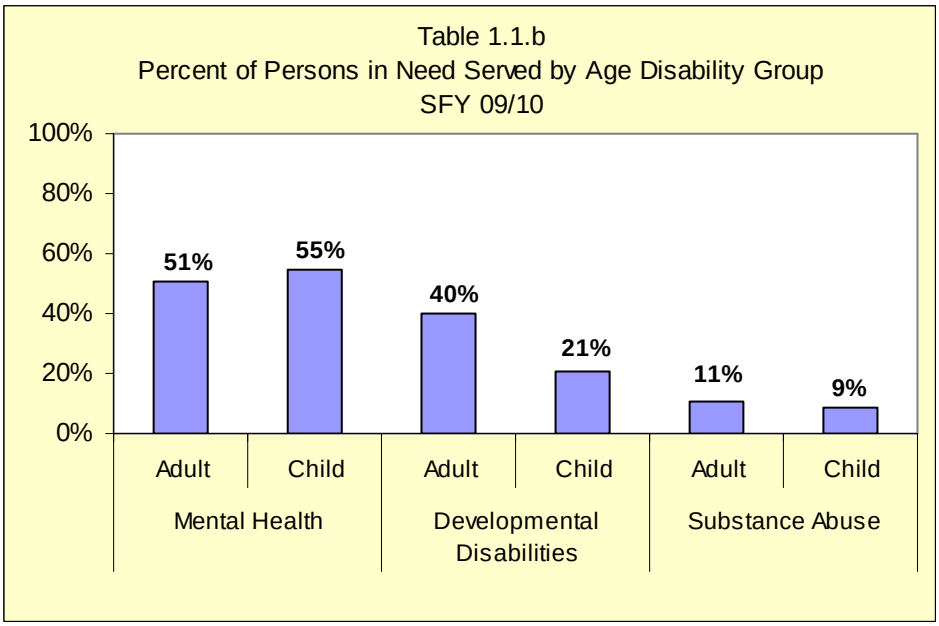
The Division is committed to serving individuals with mental health, developmental disabilities, and substance abuse needs in their communities rather than in institutional settings. Tracking the number of persons in need who receive community-based services (*treated prevalence*) through the public MH/DD/SAS system provides a barometer of progress on that goal.

Not all persons in need of MH/DD/SA services will seek help from the public system. Those who have other resources, such as private insurance, will contact private providers for care. However, many – especially those with mental health and/or substance abuse issues – will not seek help at all, due to a lack of knowledge of what services are available or how those services can help. In addition, cultural stigmas against admitting problems and distrust of governmental programs keep others from seeking help.[3]

Table 1.1.b, on the next page, presents the percent of persons estimated to be in need who received publicly-funded community-based services during the last state fiscal year.[4] This percentage provides information that the Division uses to establish reasonable targets and to evaluate the need for future changes to fiscal or programmatic policies.

[3] The Division of MH/DD/SAS is charged with serving persons ages 3 and above. The Division of Public Health is responsible for all services to children from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.The LME Administrative Cost Model, developed by Anthony Broskowski and used as a basis for LME funding, assumes that 48% of adults and 40% of children in need will be served through the public MH/DD/SAS system.

[4] The number of persons in need of services (the denominator) includes North Carolinians that the state's MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA).



SOURCE: Medicaid and State Service Claims Data. July 1, 2009 - June 30, 2010.

As seen in Table 1.1.b., the state's public system serves only 11% of adults estimated to have substance abuse disorders compared to 51% of adults estimated to have mental health disorders and 40% of adults with developmental disabilities. This is, in part, a reflection of the larger percentage of individuals with mental health disorders and developmental disabilities who are Medicaid-eligible than the percentage of Medicaid-eligibility of individuals with substance abuse disorders.

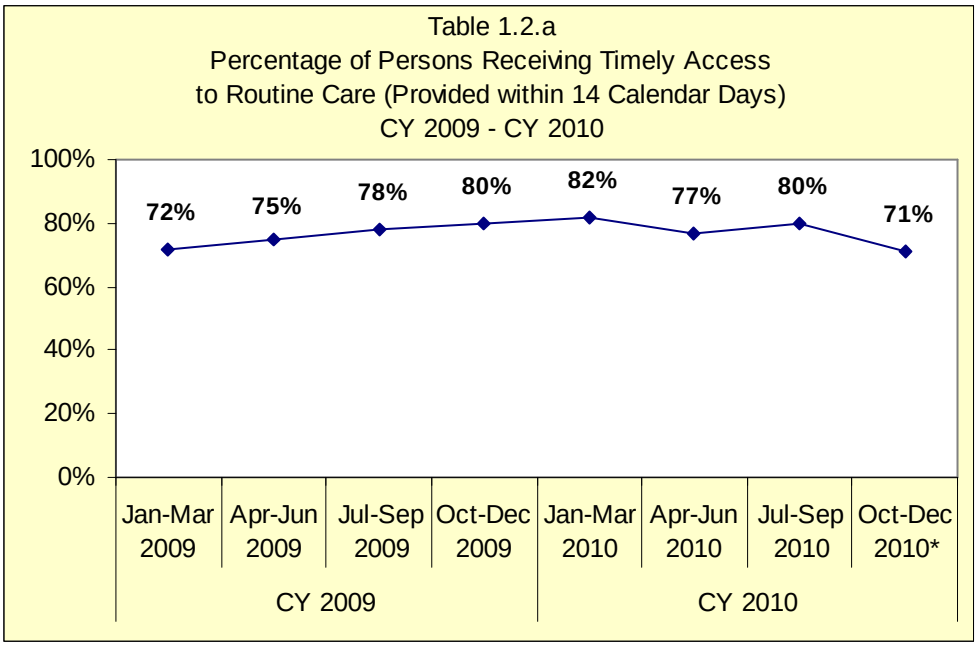
The state serves 55% of children and adolescents (ages 3-17) estimated to need mental health (MH) services and 21% of children and adolescents (ages 3-17) estimated as needing developmental disabilities (DD) services. Nine percent of adolescents (ages 12-17) projected to be in need of substance abuse (SA) services receive them through the state's MH/DD/SA service system.

Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure[5] that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that results in more trauma to the individual and results in more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

Table 1.2.a, on the next page, shows fluctuation in the percentage of consumers who seek routine (non-urgent) care and are actually seen by a provider within fourteen days of requesting services (the last quarter of the most recent calendar year had a low of 71% whereas the beginning of that same calendar year had a high of 82%). In the last quarter of CY 2010 the percent of those who are seen within two hours in emergency situations and within 48 hours in urgent situations is even higher, at 99% and 82% respectively (not shown). (Note: There were technical changes in the way this data is reported by LMEs in the last quarter of the calendar year.)

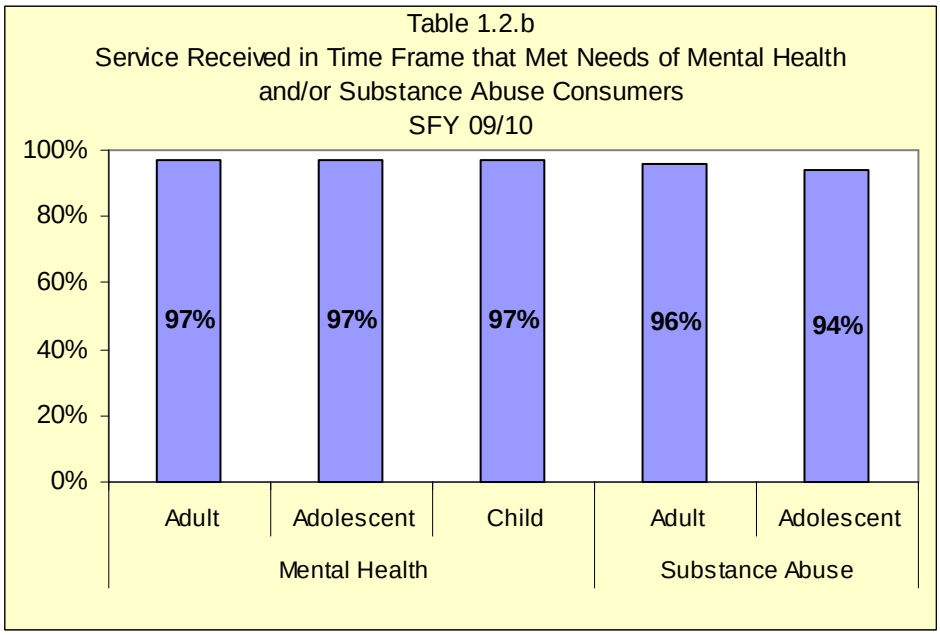
[5] Health Plan Employer Data and Information Set (HEDIS©) measures.



SOURCE: Data from LME screening, triage, and referral logs submitted to the NC Division of MH/DD/SAS as part of DHHS-LME Performance Contract. *Note: The methodology for reporting data changed at this time.

The Division continues to work with LMEs to improve consumers receiving their first services in a timely fashion.

As shown in Table 1.2.b below, almost all mental health and substance abuse consumers or parents of child consumers (regardless of age group) reporting data during their initial assessment in SFY 2009-10 stated that services were received in a time frame that met their needs.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010.

Due to expected increases in people seeking publicly funded services coupled with budget cuts in funding of services, the Division expects future reports to show a decreased percent of consumers meeting the standard for timely access, as LMEs and providers try to balance competing goals of serving increased numbers of people and providing timely and sufficient services to those who need help.

Domain 2: Individualized Planning and Supports

Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what is important to the individual – and their family, where appropriate – are more likely to engage them in service and encourage them to take charge of their lives. Services that address what is important for them produce good life outcomes more efficiently and effectively.

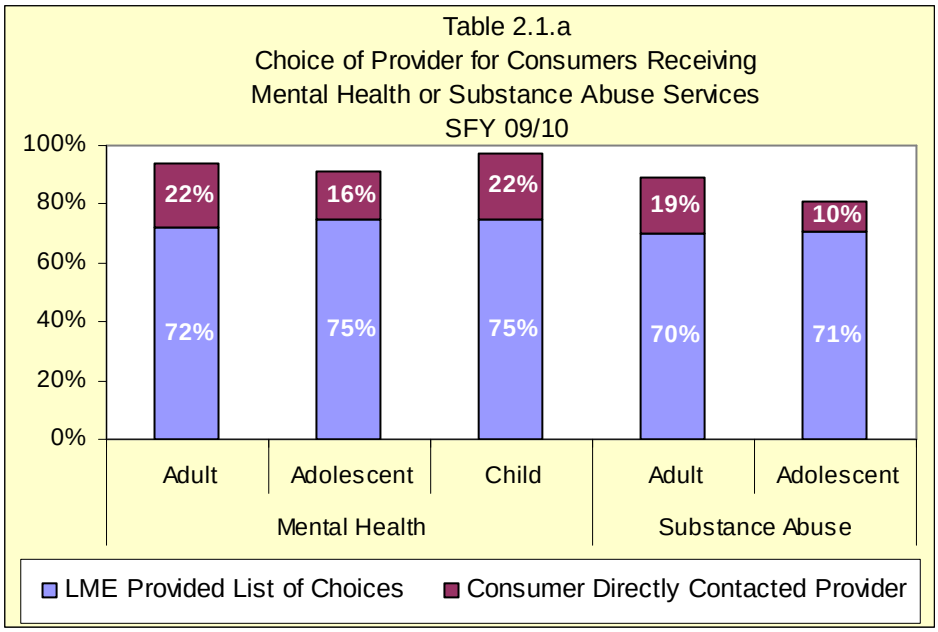
The CMS Quality Framework encourages measuring the extent to which consumers are involved in developing their service plans, have a choice among providers and receive assistance in obtaining and moving between services when necessary.

Measure 2.1: Consumer Choice

Offering choices is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a sufficient number of qualified providers to serve those requesting help.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.a): Finding the right provider can mean the difference between willing engagement in services or discontinuation of services before recovery or stability can be achieved. With sufficient provider capacity, consumers have an opportunity to select services from agencies that meet their individual scheduling and transportation requirements, address their individual needs effectively and encourage them in a way that feels personally comfortable and supportive.

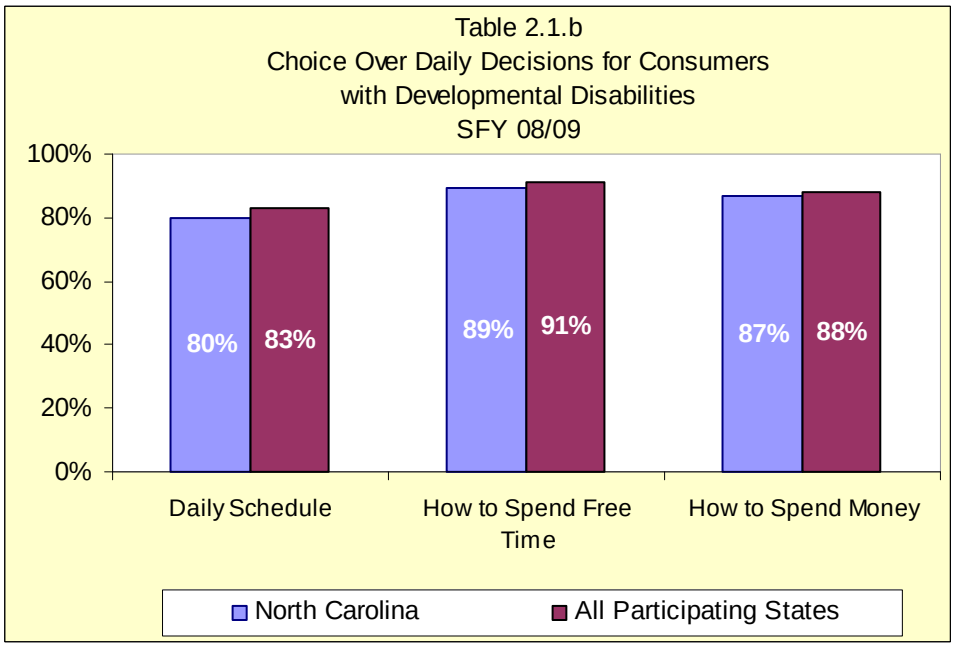
About three-fourths of mental health consumers (regardless of the age group) and 7 out of 10 adult and adolescent substance abuse consumers reporting outcomes data in SFY 2009-10 said that the LME gave them a list of providers from which to choose services. (See Appendix D for information on NC-TOPPS). The majority of the remaining consumers reported they contacted the provider directly and a very small percentage of consumers reported they did not receive a list of options.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010.

Consumers with Developmental Disabilities (Table 2.1.b): Having a choice of providers, while important, is not the only component of control consumers seek. Having control of one's life also requires being able to exercise choice in making both major and routine life decisions.

In SFY 2008-09 interviews, an overwhelming majority of consumers with DD reported choosing or having some input in how they spend their day (80%), free time (89%), and money (87%). Overall, there was very little difference between North Carolina consumers and consumers from all states participating in the project. (See Appendix D for more information on this survey.)



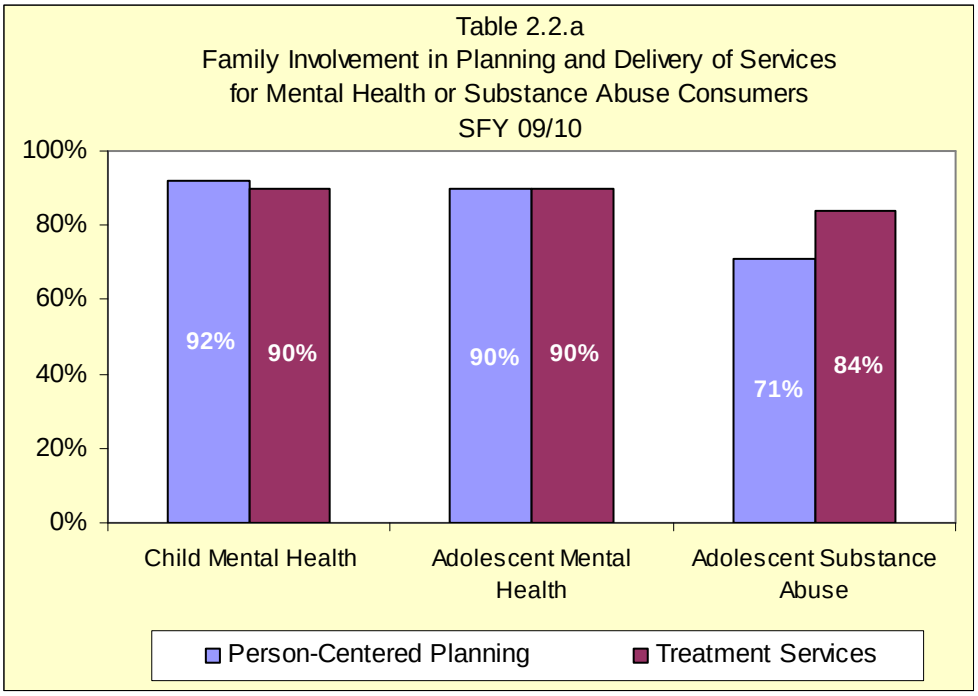
SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2008-09, North Carolina (NC) compared to All Participating States (All).

Measure 2.2: Person-Centered Planning

A Person-Centered Plan (PCP) is the basis for individualized planning and service provision. It allows consumers and family members to guide decisions on what services are appropriate to meet their needs and goals and tracks progress toward those goals. The Division requires a PCP for individuals who receive publicly-funded community intervention services and developmental disability services and has implemented a standardized format and conducted training to ensure statewide adoption of this practice.

As the following tables show, a large majority of consumers are involved in the service planning and delivery process.

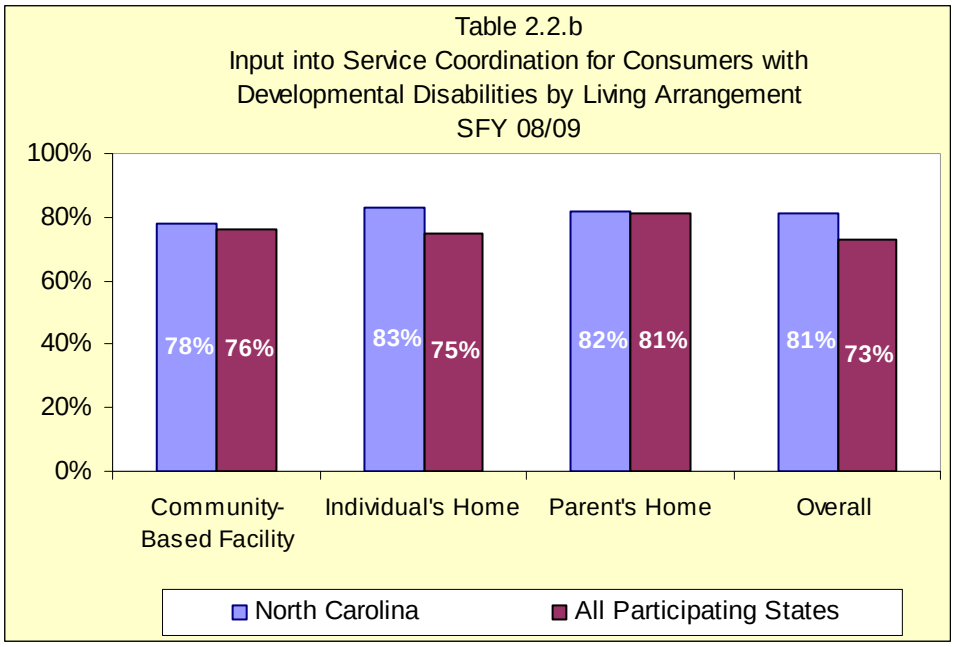
Consumers with Mental Health and Substance Abuse Disabilities (Table 2.2.a): Table 2.2.a shows that the overwhelming majority of families of children and adolescents with mental health disorders (nine out of every ten families) are involved in service planning and delivery. For families of adolescents with substance abuse disorders, approximately seven out of ten are involved with service planning and 84% are involved with service delivery.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. 3 Month Update Interviews conducted July 1, 2009 - June 30, 2010

The greater involvement of parents of children and adolescents may reflect the state's efforts to institute a system of care that strongly encourages family ownership of service planning and delivery. In taking a person-centered approach to services, providers have to strike a balance between honoring consumers' preferences and encouraging the involvement of an individual's natural support network.

Consumers with Developmental Disabilities (Table 2.2.b): In SFY 2008-09, the large majority of North Carolina consumers with developmental disabilities (81%) reported that their case manager is responsive to them regarding services and supports needed (see Table 2.2.a below). North Carolina consumers, regardless of where they live, were more likely to report involvement in service coordination compared to consumers in all states using this survey. (See Appendix D for more information on this survey.)



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2008-09, North Carolina (NC) compared to All Participating States (All).

The Division, LMEs and providers continue to incorporate person-centered thinking into all aspects of the service system. The Division expects recent revisions to the standardized Person-Centered Planning form and continued trainings on its use to support gradual improvements in this area.

Domain 3: Promotion of Best Practice

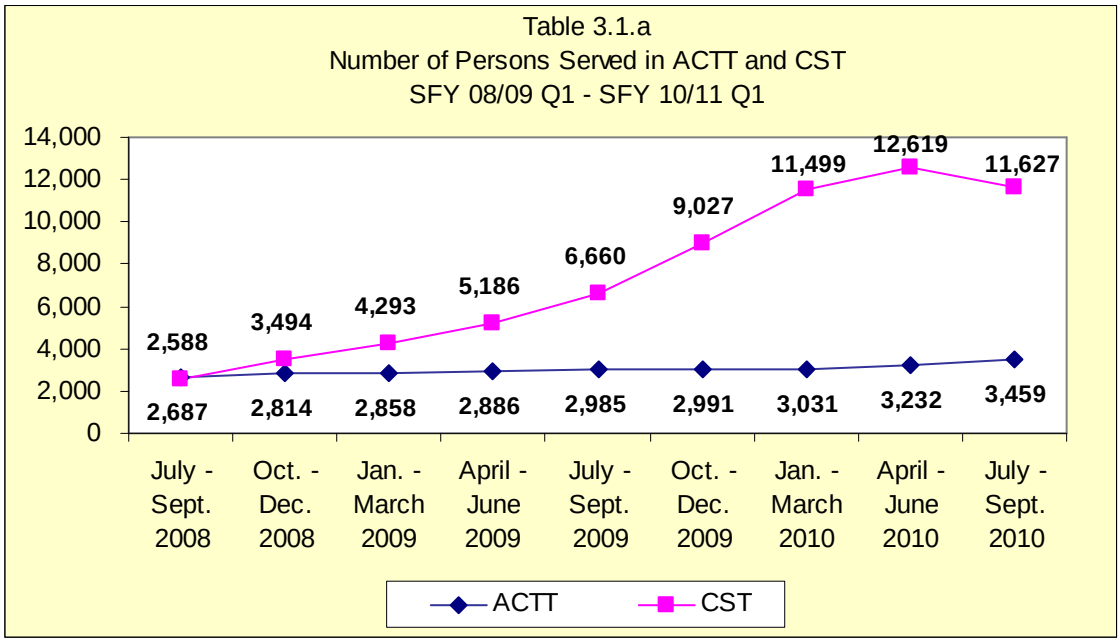
This domain refers to adopting and supporting those models of service that give individuals the best chance to live full lives in their chosen communities. It includes support of community-based programs and practice models that scientific research has shown to improve the behaviors and/or functioning of persons with disabilities. It also refers to promising practices that are recognized nationally. The Substance Abuse and Mental Health Services Administration (SAMHSA) requires states to report on the availability of evidence-based practices as part of the National Outcome Measures.

Supporting best practices requires adopting policies that encourage the use of natural supports, community resources and community-based service systems; funding the development of evidence-based practices; reimbursing providers who adopt those practices; and providing oversight and technical assistance to ensure the quality of those services.

Measure 3.1: Persons Receiving Evidence-Based Practices

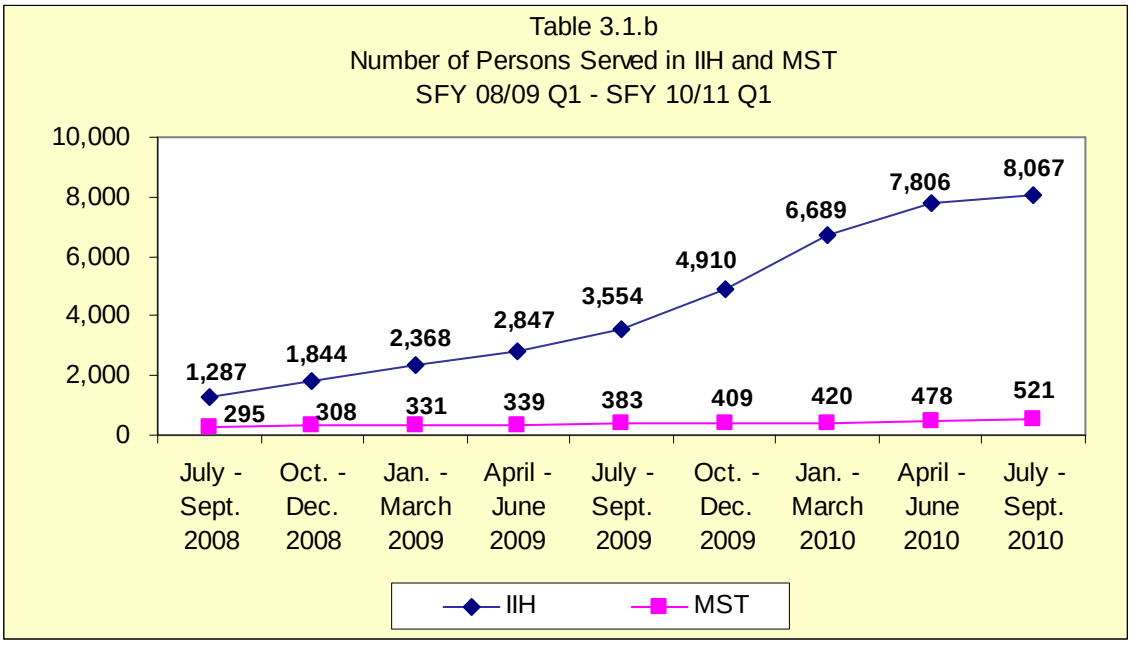
Consumers with Mental Health Disabilities: Adults with severe and persistent mental illnesses often need more than outpatient therapy or medications to maintain stable lives in their communities. Community Support Teams (CST) and Assertive Community Treatment Teams (ACTT) are designed to provide intensive, wrap-around services to prevent frequent hospitalizations for these individuals and help them successfully live in their communities. As shown in Table 3.1.a, on the next page, the number of persons served in ACTT has been climbing steadily over the past two years (roughly increasing by 29 percent), while the number of persons served in CST has more than quadrupled since the first quarter of SFY 2008-09. This increase is likely a response to the discontinuation of community support. The decline since June 2010 is a result of the Department's implementation of Critical Access Behavioral

Health Agencies (CABHA) as the only providers who can offer this service. (See the Fall 2010 report for more details on this initiative.) The Division is carefully monitoring this service and taking steps to ensure it is appropriate for the individuals served.



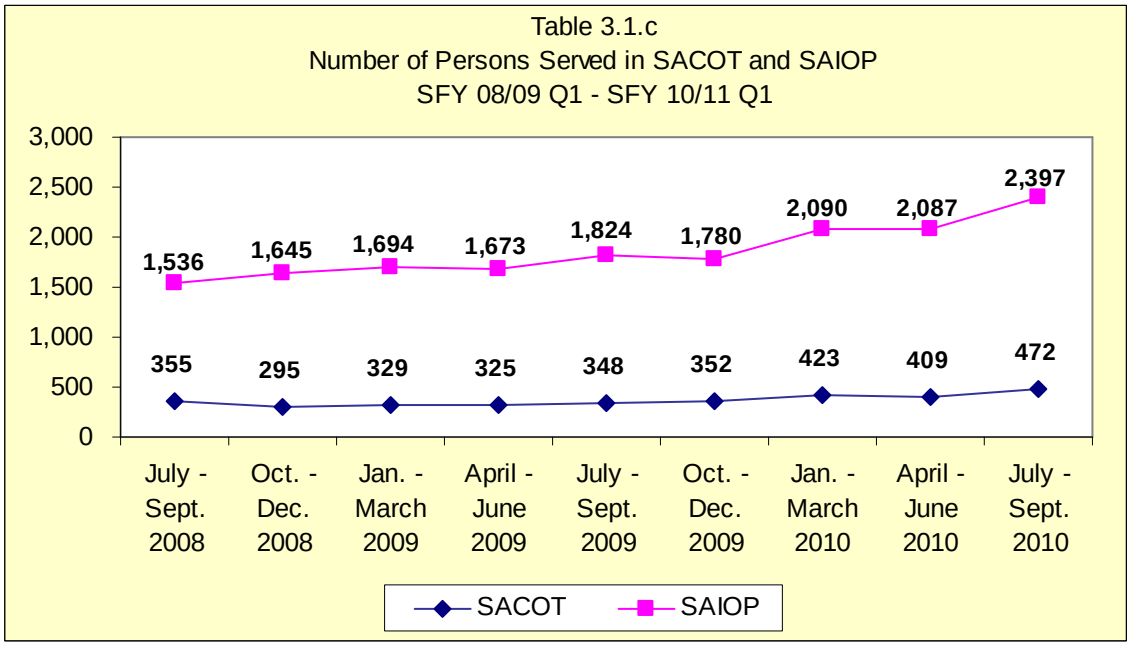
SOURCE: Medicaid and State Service Claims Data. July 1, 2008 - September 30, 2010.

Best practice services that support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems require involvement of the whole family. Two of these best practices – intensive in-home (IIH) and multi-systemic therapy (MST) – help reduce the number of children who require residential and inpatient care. Table 3.1.b, on the next page, shows that the number of persons served in IIH has increased more than five hundred percent since the first quarter of SFY 2008-09. During the same time period, the number of persons served in MST has increased 77%. Like CST, the growth and leveling off of IIH is likely a response to the discontinuation of community support and the implementation of CABHA as the only agencies that can offer IIH. The Division is working with these selected agencies to ensure appropriate use.



SOURCE: Medicaid and State Service Claims Data. July 1, 2008 - September 30, 2010.

Consumers with Substance Abuse Disabilities: Recovery for individuals with substance abuse disorders requires service to begin immediately when an individual seeks care and to continue with sufficient intensity and duration to achieve and maintain abstinence. The Substance Abuse Intensive Outpatient Program (SAIOP) and Comprehensive Outpatient Treatment (SACOT) models support those intensive services using best practices, such as motivational interviewing techniques. While SAIOP has experienced an increase of 56% in the number of persons served during the last nine quarters, SACOT has increased by just 33% in the same time period, as seen in Table 3.1.c below.



SOURCE: Medicaid and State Service Claims Data. July 1, 2008 - September 30, 2010.

The increase in persons receiving these best practice services has coincided with the decrease in inappropriate use of Community Support as a base service for many consumers. This rebalancing reflects a move to more person-centered decisions about appropriate service levels.

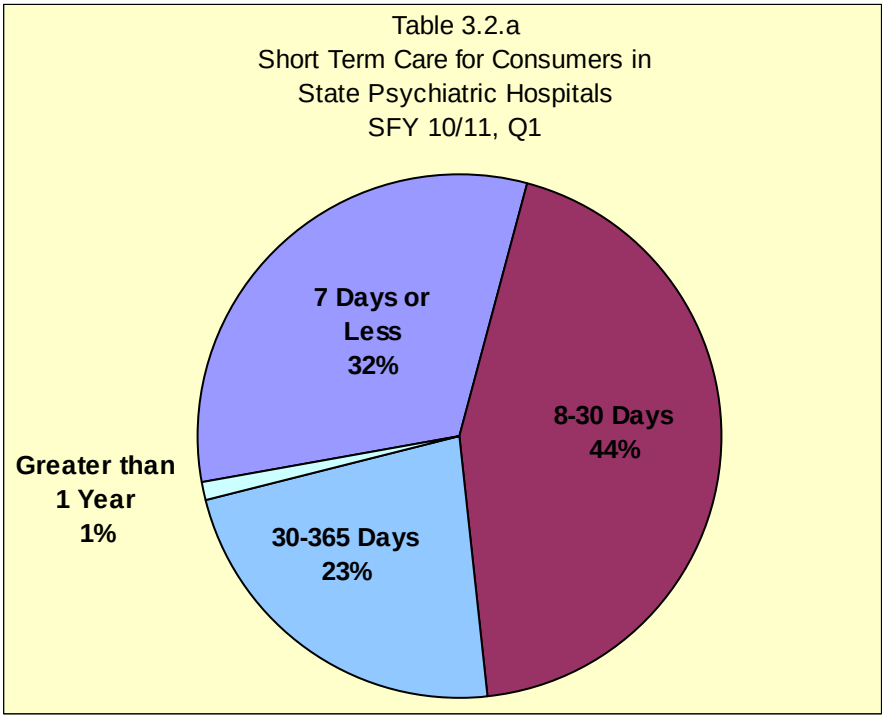
The Division encourages continued growth in these evidence-based practices for persons with substance abuse issues.

Measure 3.2: Management of State Facility Usage

Community Crisis Care and Short-Term Use of State Hospitals: North Carolina is committed to developing a service system in which individuals are served in their home communities whenever possible. This is a particularly critical component of care in times of crisis. Service systems that concentrate on preventing crises and providing community-based crisis response services can help individuals to maintain contact with and receive support from family and friends, while reducing the use of state-operated psychiatric hospitals.

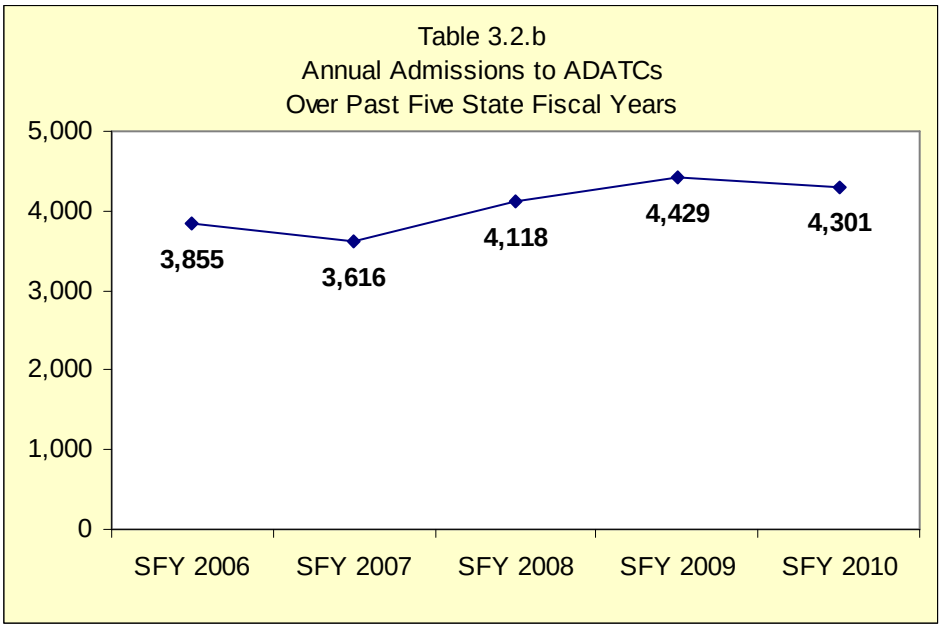
As has been reported previously, North Carolina has historically used its state psychiatric hospitals to provide more short-term care (30 days or less) than other states. The majority of states do not have short-term care units in their state hospitals. Instead acute care is provided in private hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. As a result North Carolina has served more people overall in its state hospitals and average lengths of stay have been shorter than the national average.

Table 3.2.a shows that just over three-fourths (76%) of discharges during the first quarter of SFY 2010-11 were for consumers with lengths of stay for 30 days or less. Of the 1,051 discharges, 32% (n=334) were for consumers who discharged within 7 days of admission, a drop of 7 percentage points from the first quarter of the previous fiscal year. Stays of 8-30 days increased by two percentage points and stays of 30 days to one year increased by 5% during the same time period.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS)
Data for discharges during July 1 - September 30, 2010; N=1,051 discharges.

Acute Care in State Alcohol and Drug Treatment Centers: In contrast to efforts to *reduce* the use of state psychiatric hospitals for acute care, the Division continues working to *increase* the use of state Alcohol and Drug Treatment Centers (ADATCs) for acute care. ADATCs are critical resources to serve individuals who are exhibiting primary substance abuse problems that are beyond the treatment capacity of local community services, but for whom psychiatric hospitalization is not appropriate. As shown in Table 3.2.b below, admissions to all ADATCs increased by approximately 12% over the past five state fiscal years.



SOURCE: DMH/DD/SAS Consumer Data Warehouse (CDW), Annual Statistical Reports for Alcohol and Drug Abuse Treatment Centers. Admissions from SFY 2006 through SFY 2010.

Measure 3.3: Continuity of Care Following Discharge from State Facilities

Continuity of care for consumers after discharge from a state facility is critically important in preventing future crises and supporting an individual's successful transition to community living. A follow-up service within 7 calendar days of discharge from a state facility is the current NC requirement in the *SFY 2011 DHHS-LME Performance Contract*.[6] Developmental centers adhere to a stricter best practice standard, which ensures that individuals moving to community settings receive extensive pre-discharge planning and immediate care upon discharge.

For individuals moving from the developmental centers to the community, transition planning begins many months prior to discharge.[7] This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center. During

[6] The Division adopted the Health Plan Employer Data and Information Set (HEDIS©) measure. However, best practice is for individuals with MH or SA disorders to receive care within 3 days. As the community service system stabilizes, the Division will increase expectations for timely follow-up community care.

[7] Best practice for persons with DD moving from one level of care to another is to receive immediate follow-up care that adheres to prior planning decisions that involved all relevant parties.

Calendar Year 2010, a total of 17 individuals were discharged from the general population of the developmental centers to the community.[8] All 17 individuals went directly from services at the developmental centers to services in the community. Table 3.3.a shows the type of community setting to which the individuals moved.

Table 3.3.a
Follow-Up Care for DD Consumers Discharged from State Developmental Centers*
Calendar Year 2010

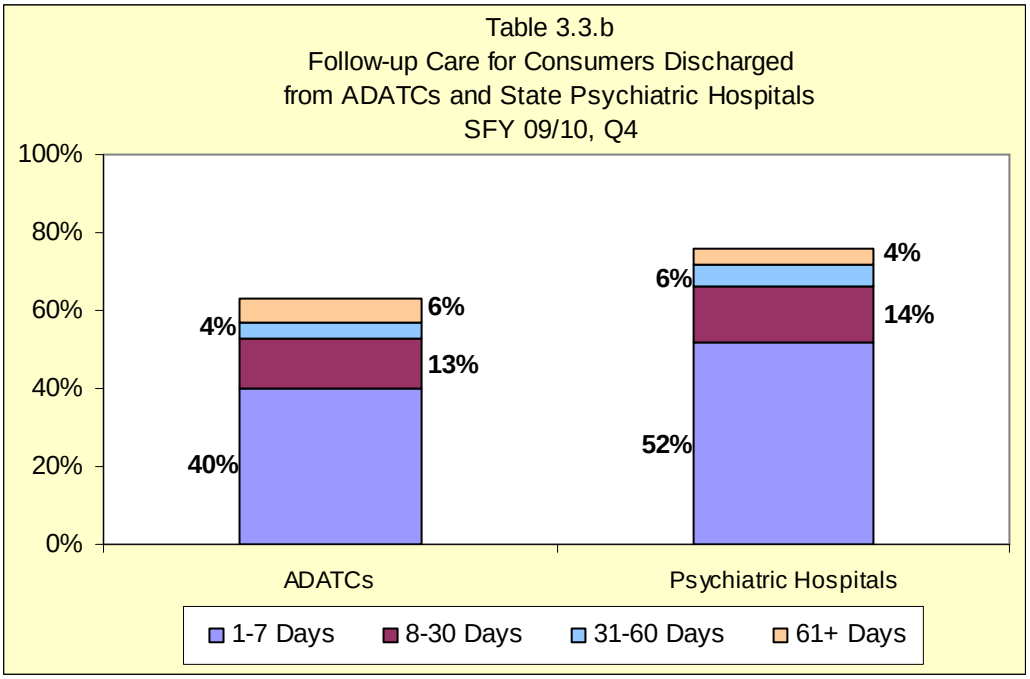
Time Period	Number of Individuals Moved to Community	Type of Community Setting
January – March 2010	4	1 to ICF-MR group home 1 to supervised living home 1 to natural family 1 to medical facility/hospital
April – June 2010	4	4 to supervised living home
July – September 2010	4	1 to ICF-MR group home 2 to supervised living home 1 to natural family
October – December 2010	5	2 to ICF-MR group home 1 to supervised living home 1 to alternative family living 1 to family home

*State developmental centers include J. Iverson Riddle Center, Murdoch Center, and Caswell Center.

Over the past few years the Division has worked closely with LMEs to improve care coordination and follow-up services. Because of the emphasis on improving the timeliness of follow-up care for persons discharged from state psychiatric facilities and ADATCs, the state has seen notable increases in consumers receiving care in the community following discharge. As shown in Table 3.3.b, on the next page, more than six out of ten (63% out of 781) of persons discharged from state ADATCs are seen for follow-up care, with four out of ten (40%) receiving care within 7 days of discharge. One year ago, slightly less than one-third of consumers discharged from an ADATC were seen within 7 days. Follow-up care for the state psychiatric hospitals is somewhat better. Two-thirds (66% out of 1,092) of persons discharged from state psychiatric hospitals receive follow-up care, a little more than half (52%) being

[8] This number does not include persons discharged from specialty programs or respite care in the developmental centers.

seen within 7 days. One year ago, it was just under half (49%) of consumers discharged from a state psychiatric hospital were seen within 7 days. The Division will continue to emphasize this critical continuity of care issue with the expectation that more consumers will be seen in a timely manner.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Discharge Data (for HEARTS discharges April 1 - June 30, 2010); Medicaid and State Service Claims Data (for claims paid through October 31, 2010)

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system reform is building a recovery-oriented service system. Recovery for persons with disabilities means having independence, stability and control over one's own life, being considered a valuable member of one's community and being able to accomplish personal and social goals.

All people – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family and to participate positively in the larger community. The SAMHSA National Outcome Measures and the CMS Quality Framework include measures of consumers' perceptions of service outcomes and measures of functioning in a variety of areas, including:

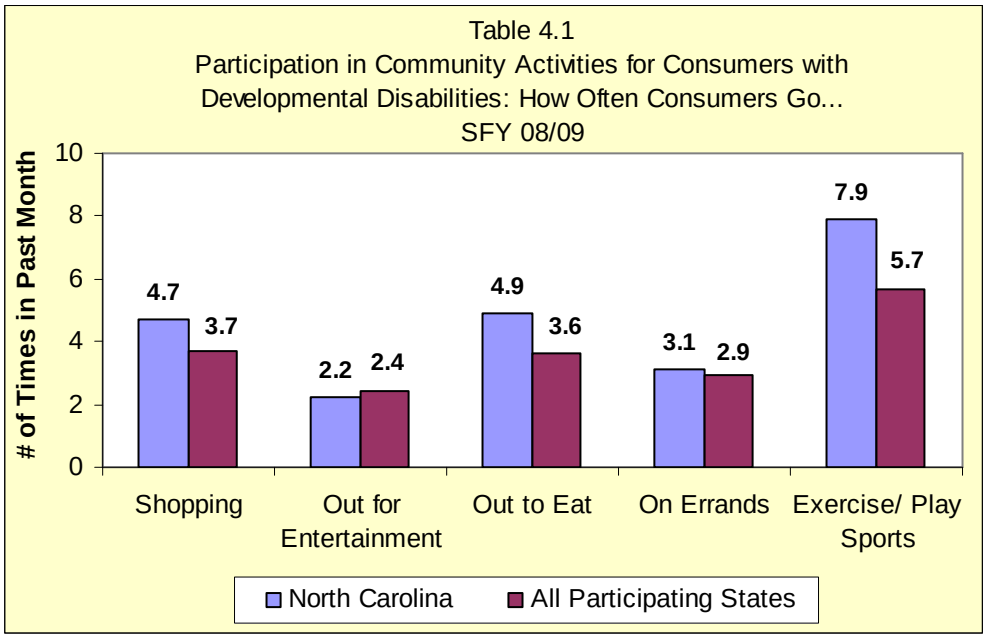
- Symptom reduction, abstinence, and/or behavioral improvements.
- Housing stability and independence.
- Employment and education.
- Social connectedness.
- Reduction in criminal involvement.

The Division is currently working to ensure that individual progress on these consumer outcomes is addressed as a regular part of developing person-centered plans for every consumer. Based on analysis of current information, the Division has identified improvements in housing and employment opportunities as strategic objectives for the next three years. Division and local agencies will continue analyzing

consumer outcomes data to monitor progress in these areas and to identify other areas that require policy development or targeting of funds for training and technical assistance in clinical practice and for other service system enhancements.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

In annual interviews with consumers with developmental disabilities in SFY 2008-09, the overwhelming majority of North Carolina consumers reported participation in community life (see Table 4.1 below). In SFY 2008-09, the Consumer Survey assessed how often individuals participated in everyday activities in their communities, such as shopping, entertainment, going out to eat, running errands, and exercise/playing sports. North Carolina consumers participated in shopping, eating out, and exercising more often in a month than consumers among all participating states. North Carolina consumers did not differ significantly from consumers among all states using the survey in the areas of going out for entertainment and running errands. (See Appendix D for details on this survey.)



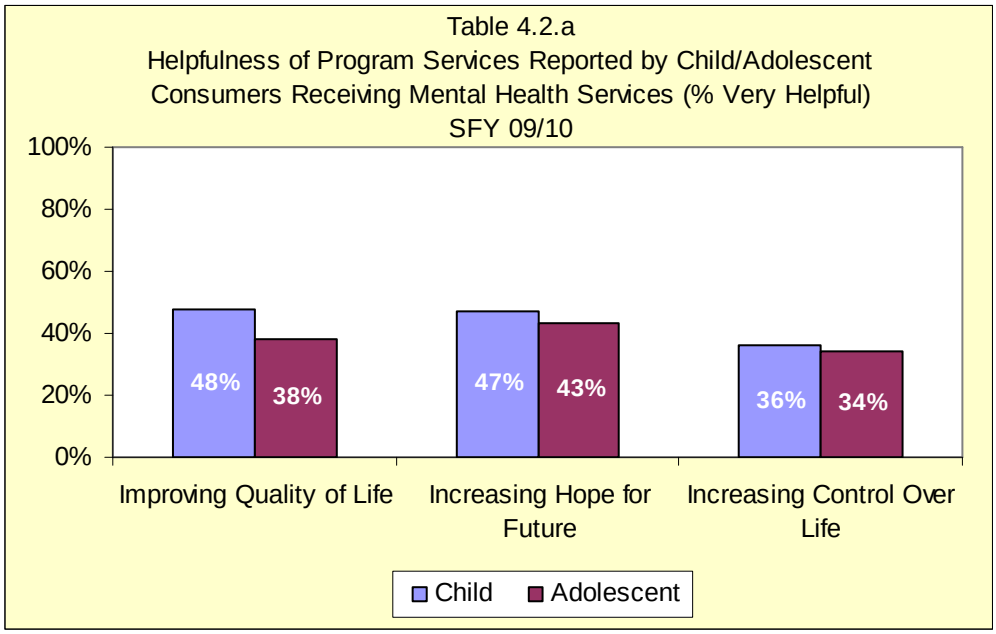
SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2008-09, North Carolina (NC) compared to All Participating States (All).

Measure 4.2: Outcomes for Persons with Mental Health Disorders

For persons with mental illness, successful engagement in services for even three months can begin to build the stability and control that improve consumers' lives and give them hope for further recovery. While three months is insufficient time to judge the long-term effect of treatment, building hope at the outset is an important factor in engaging individuals in their treatment and sustaining improvements over time.

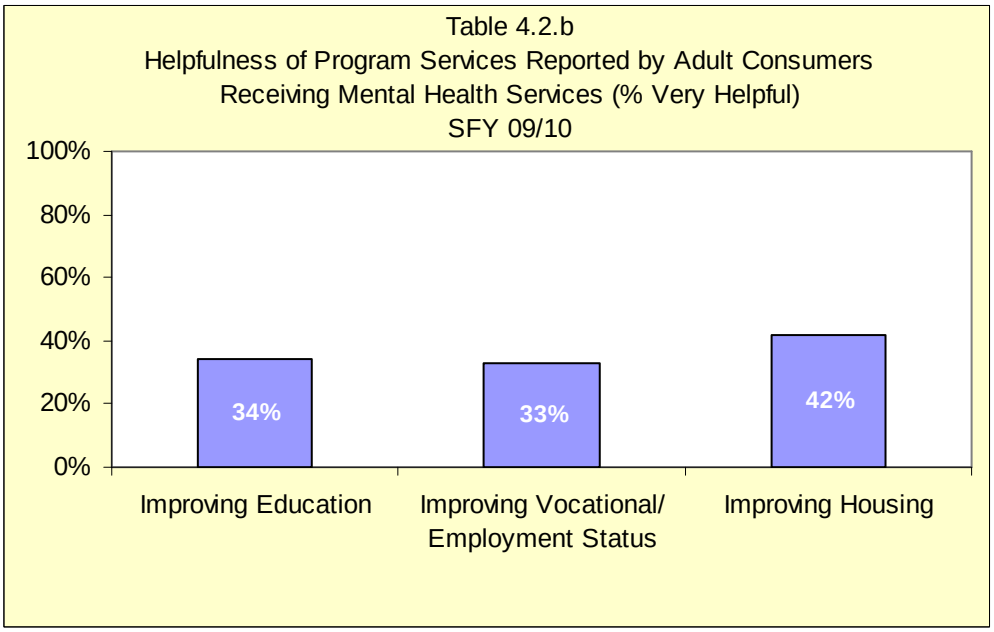
Table 4.2.a, on the next page, shows how adolescent mental health consumers and parents/guardians of child mental health consumers in SFY 2009-10 perceived the impact of the first three months of treatment in three important quality of life indicators. Just under half of parents/guardians reported their child's services were very helpful in improving their child's quality of life and hope for future, 48% and 47% respectively. A little more than one-third (36%) of parents/guardians also stated services were very helpful in increasing their child's control over his/her life. Adolescents, however, reported slightly lower rates for helpfulness of program services for all three quality of life indicators. Slightly less than four out

of ten adolescents reported services had improved their quality of life. Forty-three percent stated services were very helpful in increasing their hope about the future and approximately one-third (34%) of adolescents reported that services were very helpful in increasing control over their lives. (See Appendix D for details on the NC-TOPPS system used to collect this data.)



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 matched to 3-Month Update Interviews.

For adults with mental illness, housing and employment are important to regaining personal control of one's life. Table 4.2.b below shows how adult mental health consumers in SFY 2009-10 rated the impact of the first three months of treatment in three key areas of their lives. (See Appendix D for details on the NC-TOPPS system used to collect this data.)



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 matched to 3-Month Update Interviews.

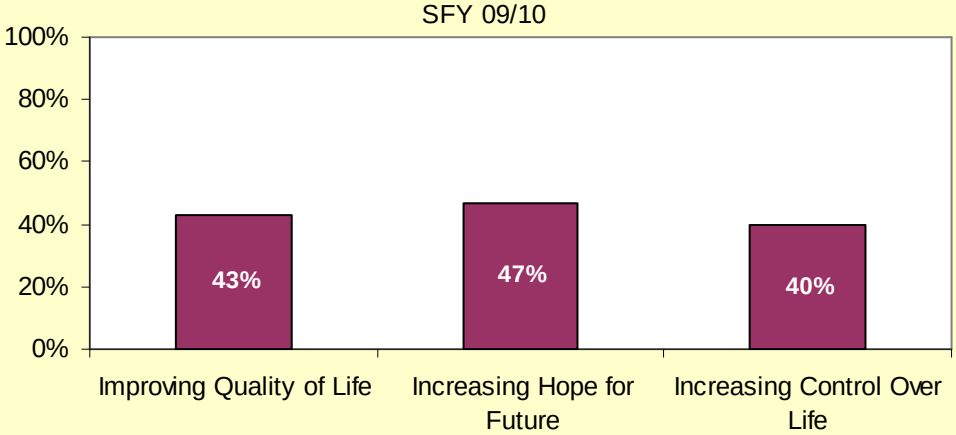
- Approximately one-third of adults (34%) reported that services helped improve their education.
- One-third of adults (33%) reported improvements in their vocational/employment status.
- Four out of ten (42%) adults reported that services helped improve their housing situation.

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

For persons with substance abuse disorders, like those with mental illness, successful engagement in services for even three months can begin to build the stability and control that improve consumers' lives and give them hope for further recovery. Successful engagement in the first three months of service is especially critical for this population of consumers, because of the chronic, debilitating nature of addictions.

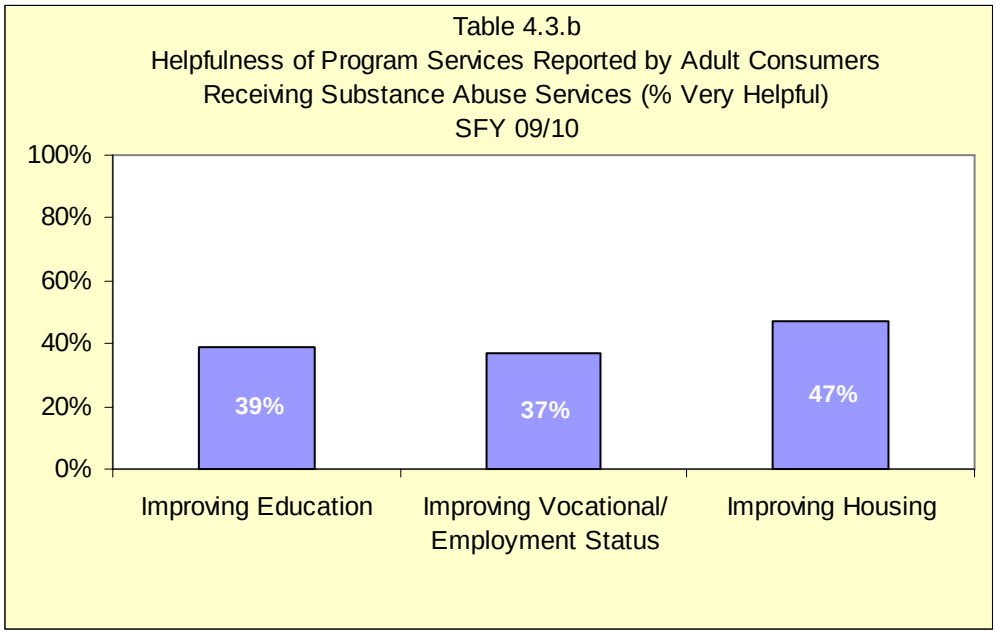
As seen in Table 4.3.a below, 43% of adolescent substance abuse consumers in SFY 2009-10 stated that program services were very helpful in improving their quality of life, slightly less than half reported services were helpful in increasing their hope about the future (47%), and four out of ten reported services were helpful in increasing control over their own life.

Table 4.3.a
Helpfulness of Program Services Reported by Adolescent Consumers Receiving Substance Abuse Services (% Very Helpful)
SFY 09/10



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 matched to 3-Month Update Interviews.

Table 4.3.b, on the next page, shows how adult substance abuse consumers in SFY 2009-10 perceived the impact of the first three months of treatment in three essential areas of their lives. Again, perceptions after three months of service is primarily an indicator of the individual's hope for recovery and engagement in services, both of which are key for achieving and sustaining improvements over time. (See Appendix D for details on the NC-TOPPS system used to collect this data.)



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted July 1, 2009 - June 30, 2010 matched to 3-Month Update Interviews.

- Approximately four out of ten adult SA consumers reported that services were vey helpful in improving their education.
- Thirty-seven percent of adult SA consumers reported services were very helpful in improving their vocational/employment status.
- Close to half (47%) of adult SA consumers reported program services as very helpful in improving their housing situation.

Domain 5: Quality Management Systems

Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division incorporates the processes as spelled out in the CMS Quality Framework for Home and Community-Based Services (see Appendix C for more information). These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled **quality assurance**, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The second set of activities, labeled **quality improvement**, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

Measure 5.1: DHHS Excels and Open Window

The Department of Health and Human Services' new initiative, "DHHS Excels" uses five categories to capture various services offered throughout the Department. Summarized versions of these five goals are:

1. Management of resources for effective service delivery and operations.
2. Prevention and wellness education to the general public.

3. Targeted prevention to at-risk populations.

4. Service provision to individuals with identified needs (community).

5. Service provision to individuals experiencing serious health needs (out of home).

Through DHHS NC Open Window database, Secretary Lanier Cansler hopes to align services by category rather than by division, so that North Carolinians will be able to view a full range of services across the Department, with fiscal and performance data at hand. The database includes a description of the service, current and projected costs, numbers served, and goals for the service. Open Window can assist consumers, families, other stakeholders to understand what services are available, the costs associated with these services, and how performance is measured. Each of the five DHHS Excels goals listed has its own objective, and every service under the goal has performance measures linked to the DHHS Excels objective. Linking DHHS Excels goals to the database offers our Division an opportunity to enhance management through transparent performance expectations for services delivered.

The model DHHS has begun leads to better collaboration and connectivity of services provided across divisions, with the goal of better outcomes for consumers. As a management tool, DHHS NC Open Window allows managers of all levels to get a complete picture of services and funding inside and outside their own division. The transparency allows more accountability and is a mechanism for improved planning, communication, feedback, and direction at the division level. The Division of MH/DD/SAS will use the revised version of Open Window as a way to meet the objectives of DHHS Excels through continuous quality improvement. We will manage services, performance, and funds through the system throughout the fiscal year, and strategize based on the information in Open Window.

Measure 5.2: Critical Access Behavioral Health Agency (CABHA) Implementation Update

As discussed in the Fall 2010 report, the Department has implemented a new category of provider agency referred to as CABHA. As of January 1, 2011 only CABHAs can provide CST, IIH, and Day Treatment services. Providers of these three services must have submitted a Letter of Attestation for CABHA certification on or before August 31, 2010 to obtain CABHA certification on or before the December 31, 2010 deadline. The following is a brief summary of the current status as of February 2011: Prior to August 31, 2010, a total of 603 providers had submitted applications, 188 agencies were certified and 68 agencies requested reconsideration. Since August 31, 2010, 106 application packets have been received, approximately 65 have been reviewed and approximately 20 of the 65 have met desk review. The CABHAs are providing services in all one hundred counties.

Domain 6: System Efficiency and Effectiveness

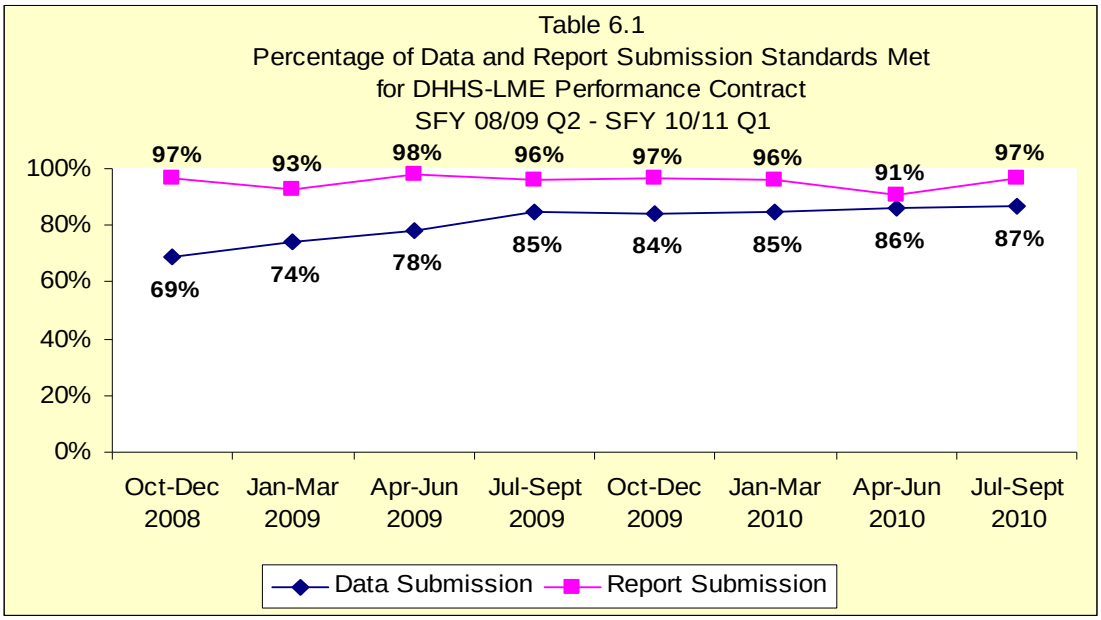
System efficiency and effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and diligent information management.

The annual *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. It lays out the requirements for each function that the LME is contracted to fulfill. In addition, the contract contains statewide measures with annual performance standards and projected targets that the Division tracks and reports on its website in the quarterly *Community Systems Progress Reports*. For SFY 2009 the Division has also begun providing this information in a one-page matrix format, called *"Critical Measures at a Glance."* The LMEs are expected to develop and implement strategies for improving areas of weakness and achieving the Division's statewide targets.

Measure 6.1: Business and Information Management

Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead. For these reasons, compliance is critical to LME and Division efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely and accurate submission of financial and consumer information. Taken together, the LMEs' compliance with reporting requirements provides an indication of the system's capacity for using information to manage the service system efficiently and effectively.

Table 6.1 shows the LMEs' submission of timely and accurate information over the past eight quarters. Data submission has risen 18 percentage points from 69% to a high of 87% while the submission of reports has fluctuated between 91% and 98% during the same time period. For all eight quarters, the percentage of report submission standards met was consistently higher than data submission.



SOURCE: Data from Quarterly Performance Contract reports, SFY 08/09 Q2 though SFY 10/11 Q1.

Measure 6.2: Performance on System Indicators

The Division continues to monitor the effectiveness of community systems through statewide performance indicators. The regular reporting of community progress assists local and state managers in identifying areas of success and areas in need of attention, as well as holds every part of the system accountable for progress toward the goals of mental health reform. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities. The *DHHS-LME Performance Contract* assigns a standard for expected performance for each critical performance measure. Table 6.2, on the next page, displays the number of LMEs that met the performance standard for the measures as referenced in the *SFY 2011 DHHS-LME Performance Contract*. The Division is working with the LMEs on areas where improvement is needed. In addition, the Division is currently reviewing performance measures for the SFY 2012 Performance Contract to determine areas where the service system has been successful, areas that need improvement, and new areas to focus efforts on in the future.

Table 6.2
Number of LMEs that Met the Performance Standard on Critical Performance Measures
(N=23 LMEs)
SFY 2010-11, 1st Quarter

Critical Performance Measure	Sub-Measure	Number of LMEs That Met the Performance Standard
Timely Access to Care	Emergent	23
	Urgent	20
	Routine	20
Services to Persons in Need	Adult MH	20
	Child MH	19
	Adult DD	20
	Child DD	16
	Adult SA	20
	Adolescent SA	22
Timely Initiation/ Engagement in Services	MH: 2 Visits in 14 Days	20
	MH: 4 Visits in 45 Days	15
	DD: 2 Visits in 14 Days	16
	DD: 4 Visits in 45 Days	13
	SA: 2 Visits in 14 Days	20
	SA: 4 Visits in 45 Days	20
Effective Use of State Psychiatric Hospitals	1-7 Days of Care	22
State Psychiatric Hospital Readmissions	30-Day Readmissions	19
	180-Day Readmissions	21
Timely Follow-Up After Inpatient Care	ADATCs: Seen in 1-7 Days	22
	State Psychiatric Hospitals: Seen in 1-7 Days	18
Child Services in Non-Family Settings		23

Measure 6.3: Efficient Management of Service Funds

In response to N.C. Session Law 2008–107, Section 10.15(x), which required the Department to return the service authorizations, utilization reviews, and utilization management (UM) functions to the LMEs, utilization management of Medicaid behavioral health services is now occurring with Eastpointe and the Durham Center LMEs. As of September 20, 2010, all providers for recipients with Medicaid eligibility within The Durham Center's catchment area (Durham County) were required to submit requests for initial and concurrent authorization for mental health, developmental disabilities, and substance abuse services to The Durham Center for prior authorization. All providers for recipients with Medicaid eligibility within Eastpointe's catchment area (Duplin, Lenoir, Sampson, and Wayne counties) were required to submit requests for initial and concurrent authorization for mental health, developmental disabilities, and substance abuse services to Eastpointe for prior authorization. This change applied only to providers delivering services to recipients with Medicaid eligibility in those catchment areas. Authorization decisions are being jointly reviewed for appropriateness by the Division and the Division of Medical Assistance (DMA) through a Quality of Care Committee. The Division is keeping a close eye on the authorization process through monitoring and follow-up.

Domain 7: Prevention and Early Intervention

Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public and specific groups known to be at risk. Prevention education focuses on the nature of MH/DD/SA problems and how to prevent, recognize and address them appropriately. **Early intervention** activities target individuals who are experiencing early signs of an emerging condition to halt its progression or significantly reduce the severity and duration of its impact.

Preventing or intervening early in a potential problem is much more effective – both clinically and financially – than treating a disability that has already caused major impairments and negative consequences in an individual's and family's life. Increasing national attention is being given to preventing or minimizing the impact of mental illness and developmental disabilities in consumers' lives. SAMHSA's National Outcome Measures (NOMS) emphasize the use of evidence-based programs to educate at all levels and intervene with individuals who may be experiencing early problems associated with substance use.

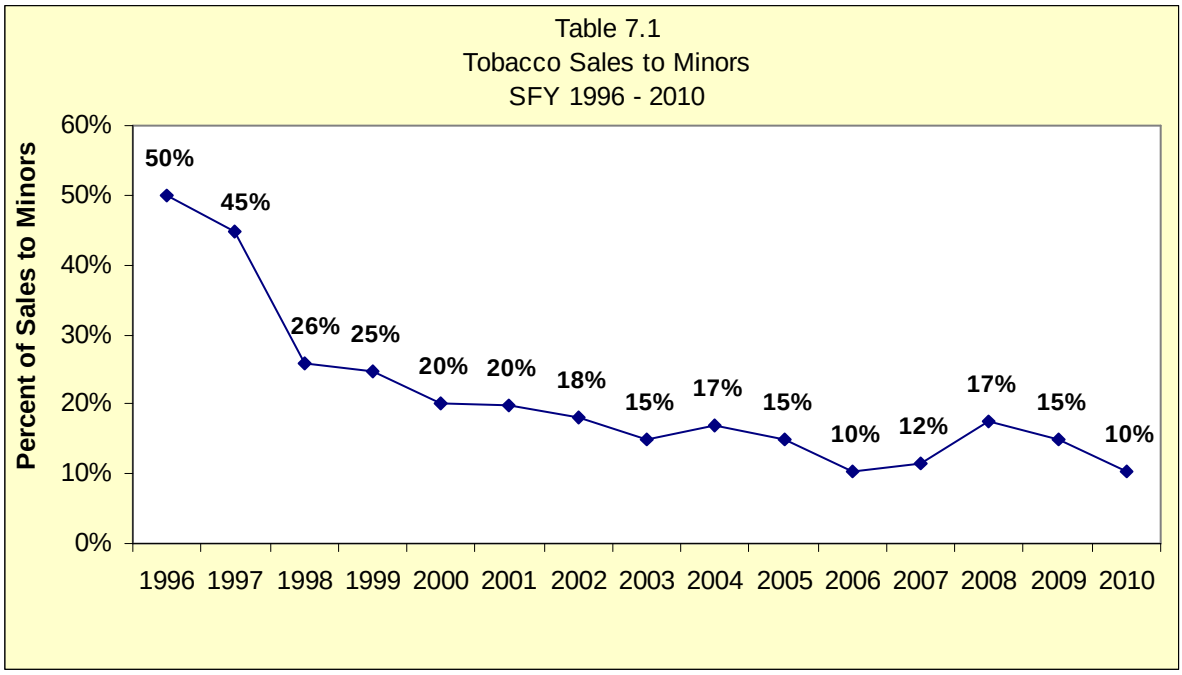
Measure 7.1: State Synar Program to Reduce Tobacco Sales to Minors

Reducing youth access to tobacco products is one component of the state's comprehensive program to prevent and reduce tobacco use among young people. The Federal Synar Amendment, Section 1926 of the Public Health Service Act, requires all states to conduct specific activities to reduce youth access to tobacco products.

As part of the DHHS-LME Performance Contract, each LME is required to work with its providers to implement Synar activities and report them to the Division twice a year. LME activities include:

- Designation of a liaison to provide community leadership in reducing youth access to tobacco products;
- Provision of at least 8 hours per month of consultation, education and primary prevention regarding youth access through community collaboration, merchant education, law enforcement, and media/public relations activities; and
- Documentation and reporting of activities through a standardized reporting format.

As part of Synar activities, the state conducts annual random, unannounced inspections of tobacco retail outlets to determine merchant compliance with the state's Youth Access Law, which prohibits the sale of tobacco products to anyone under age 18. As shown in Table 7.1, the state has made steady progress since 1996 in reducing youth access to tobacco. The annual SYNAR survey has shown rates to have fallen over time from 50% in 1996 to 10% in 2010. The program has been greatly enhanced since 2002 due to grant support from the NC Health and Wellness Trust Fund.



SOURCE: Data from State Synar Youth Purchase Survey (1996-2010).

Appendix A: Legislative Background

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

> "The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals…."

In addition, NC G.S. 122C-102(c) was revised to read:

"The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on the State's progress in these performance areas."

Appendix B: SAMHSA National Outcome Measures

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

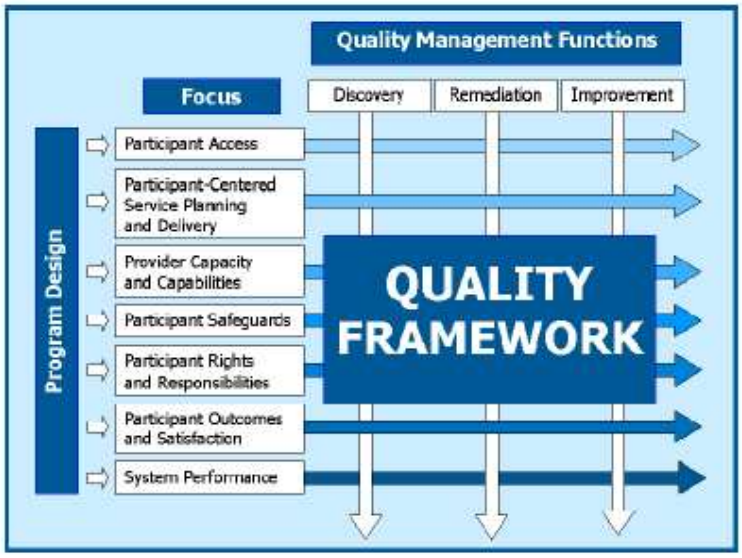
DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30 day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude ▶
	Decreased Mental Illness Symptomatology	UNDER DEVELOPMENT	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace safety; ATOD-related suspensions and expulsions; attendance and enrollment ▶
Crime and Criminal Justice	Decreased Criminal Justice Involvement	UNDER DEVELOPMENT	Reduction in/no change in number of arrests in last 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crimes ▶
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Support/Social Connectedness[1]	Clients reporting positively on social connectedness	UNDER DEVELOPMENT	Family communication around drug use ▶
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate; number served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message ▶
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	UNDER DEVELOPMENT	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost)[2]	UNDER DEVELOPMENT	UNDER DEVELOPMENT	Services provided within cost bands ▶
Use of Evidence-Based Practices	Use of Evidence-Based Practices[2]		UNDER DEVELOPMENT	Total number of evidence-based programs and strategies ▶

[1] For ATR: "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.
[2] Required by 2003 OMB PART Review.

Appendix C: CMS Quality Framework

HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered **desired outcomes** along seven dimensions.



Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).

Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	Desired Outcome
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.

CMS CENTERS for MEDICARE & MEDICAID SERVICES
NASDDDS
NASUA
APHSA American Public Human Services Association

Appendix D: Description of Data Sources

Domain 1: Access To Services

Table 1.1.a Persons in Need (*Prevalence Rates*): The estimates of the percentage of individuals who experience a mental health, developmental, and/or substance abuse disability each year come from the following sources:

MH Prevalence Rates: Prepared by NRI/SDICC for CMHS, July 6, 2010 (for the MH Block Grant)

- Children: URS Table 1: Children with Serious Emotional Disturbance, ages 9-17, by State, 2009. Note: 11% is the midpoint (10%-12%) for the LOF=60 range (SED with substantial functional impairment). The same rate was applied to children under age 9.

- Adults: URS Table 1: Number of Persons with Serious Mental Illness, age 18 and older, by State, 2009 = 5.4%.

NC Substance Abuse Prevalence Rates: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2007 and 2008, published June 2010.

- Children and Adults: Table B.20, Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2007 and 2008 NSDUH.

- Prevalence rate for adolescents (ages 12-17) is 6.57%, for adults (ages 18-25) is 19.26%, and for adults (ages 26+) is 6.42%. Total = 8.04%. Applying these age group rates to July 2010 population = 8.21% total.

DD Prevalence Rates: Larson, S., Lakin, C., Anderson, L., Kwak, N., Lee, J.H., & Anderson, D. (2000). Prevalence of MR and/or DD: Analysis of the 1994/1995 NHIS-D. MR/DD Data Brief, April 2000, Vol 2, No. 1. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration. The NHIS-D is the National Health Interview Survey (NHIS) Disability Supplement used to estimate the prevalence of people with MR and/or DD in the US Non-Institutional Population. According to the article, prevalence rates for persons ages 3-5 = 3.84%, ages 6-17 = 3.17%, and ages 18+ = 0.79%. Based on July 2010 NC projected population, and excluding children ages 0-2 who receive services from DPH, 1.30% of the total NC non-institutionalized population and 1.32% of the total population (including persons in institutions) are estimated to have MR and/or DD. If persons ages 0-2 were to be included, the prevalence rate for the non-institutionalized population would be 1.40% and the prevalence rate for the total population would be 1.42%.

Table 1.1.a and Table 1.1.b Percent of Persons in Need and Served (*Treated Prevalence*): The percent of persons in need who receive services is calculated by dividing the number of persons who received at least one Medicaid or state-funded service (based on paid claims in the Integrated Payment Reimbursement System (IPRS) and/or Medicaid claims system for the time period July 1, 2009 through July 30, 2010) by the number of persons in need of services. The number of persons in need (the denominator) includes North Carolinians that the state's MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA). The disability of the consumer is based on the diagnosis reported on the service claim. Persons with multiple disabilities are included in all relevant groups. Currently, this information is being published in the quarterly *Community Systems Progress Report*. More information on this report can be found on the web at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Table 1.2.a Percentage of Persons Receiving Timely Access to Care: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the required time period (14 calendar days) and multiplying the result by 100. The information comes from data submitted by LMEs to the Division. The Division verifies the accuracy of the information through annual on-site sampling of records. Currently, this information is being published in the quarterly *Community Systems Progress Report*. More information on this report can be found on the web at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

Table 1.2.b Service Met in Time Frame that Met Needs of Consumers: The data presented in these tables come from clinician-to-consumer initial interviews that occurred between July 1, 2009 and June 30, 2010 through the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule from all persons ages 6 and over who receive enhanced mental health services and 12 and over who receive substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at http://www.ncdhhs.gov/mhddsas/nc-topps/index.htm. Within age groups, mental health and substance abuse consumers overlap due to co-occurring disabilities.

Domain 2: Individualized Planning and Supports

Tables 2.1.a Choice Among Persons With Mental Health And Substance Abuse Disabilities: This information comes from NC-TOPPS, described in Table 1.2.b above.

Tables 2.1.b Control Over Daily Decisions for Persons With Developmental Disabilities: The data presented in these tables are from in-person interviews with North Carolina consumers in project year 2008-09, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities and their parents and guardians. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: http://www.hsri.org/nci/index.asp?id=reports.

Tables 2.2.a Family Involvement for Consumers With Mental Health And Substance Abuse Disabilities: This information comes from 3-Month update interviews conducted in SFY 2009-10 in NC-TOPPS, described in Table 1.2.b above.

Tables 2.2.b Input into Planning Services and Supports for Persons With Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.b above.

Domain 3: Promotion of Best Practices

Tables 3.1.a – 3.1.c Providers of Evidence-Based and Best Practices: Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reimbursement System (IPRS).

Table 3.2.a Short Term Care in State Psychiatric Hospitals: The data come from the Division's Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) HEARTS discharges for the period July 1 - September 30, 2010. The HEARTS data include demographic, diagnostic, length of stay and treatment information on all consumers who are served in State-operated facilities. Lengths of stay are calculated by subtracting the date of admission from the date of discharge. The percents for each length of stay grouping (1-7 days, 8-30 days, 30-365 days, and over 365 days) are calculated by dividing the total number of discharges during July 1-September 30, 2010 into the number of discharges in each length of stay grouping and multiplying by 100.

Table 3.2.b Admissions to ADATC Facilities: These data come from the Division's HEARTS data for SFY 2006 through SFY 2010 as reported in the Consumer Data Warehouse (CDW).

Table 3.3.a Follow-up Care for Consumers Discharged from State Developmental Centers: These data come from reports submitted quarterly by the developmental centers to the NC Division of State Operated Healthcare Facilities. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

Table 3.3.b Follow-up Care for Consumers Discharged from ADATCs and State Psychiatric Hospitals: The data come from HEARTS direct discharges during the period April 1 - June 30, 2010 and Medicaid and State Service Claims data for April 1- October 31, 2010. Discharges to other state-operated facilities and the criminal justice system are not included. The time between discharge and follow-up care is calculated by subtracting the date of discharge from the date of the first claim for community-based service that occurs after the discharge date. The percents of persons seen within 7 days, 8-30 days, 30-60 days, and greater than 60 days are calculated by dividing the total number discharged during the period into the number in each of the groupings of time to follow-up care.

Domain 4: Consumer Outcomes

Tables 4.1 Service Outcomes For Persons With Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.b above.

Tables 4.2 and 4.3 Service Outcomes for Individuals With Mental Health And Substance Abuse Disabilities: This information comes from initial interviews conducted in SFY 2008-09 matched with 3-Month update interviews in NC-TOPPS, described in Table 1.2.b above.

Domain 6: Efficiency and Effectiveness

Table 6.1 Business and Information Management: The data for information management come from calculations of compliance for requirements in the *DHHS-LME Performance Contract*.

Table 6.2 Efficient Management of Service Funds: This data on Utilization Review activities come from ValueOptions as well as Durham and Eastpointe LMEs.

Table 6.3 Performance on System Indicators: This information comes from the *Community Systems Progress Report, SFY 2011, 1st Quarte*r.

Domain 7: Prevention and Early Intervention

Table 7.1 Tobacco Sales to Minors: The Synar Program is named for former U.S. Representative Michael Synar. Data on the percent of sales to minors come from the annual Synar Survey which North Carolina conducts, as required by federal law, to ensure that all states are showing progress in reducing access or tobacco sales to minors. The survey has been implemented since 1996.